Claim notification

Group insurance (Health Care)

Easily report your hospitalisation online on **www.ag.be/hospi**.
You also find there tips about 'What to do in case of an hospitalisation?'

OR

Please return to:
AG
Health Care Medical Dept
Bd. E. Jacqmain 53, 1000 Brussels

CONFIDENTIAL

Please tick the appropriate box for the type of coverage that you are claiming:

☐ Hospitalisation / Medical expenses ☐ Disability annuity / Waiver of premiums

This form must be filled out by the insured and returned to AG Health Care, our medical department.
To file for a disability annuity, you will need to send the "medical certificate" form duly completed by your attending physician, as well as the occupational incapacity certificates to AG c/o the medical advisor.

Group number: ..... and/or other reference (for example your card number): .....

To be filled out for all types of claims

Employer (or former employer if retired): .....

Affiliate	Staff member	Beneficiary
Surname and first names	.....	.....
Date of birth	..... / ..... /	..... / ..... / .....
Address	.....	.....
Postal code and city	.....	.....
E-mail address	.....	.....
Telephone number (during office hours)	.....	.....
Occupation	.....	.....

Postal or bank account n°: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Account holder: .....

Period of hospitalisation: .....

Name and address of the hospital: .....

.....

Room type: ☐ Single room ☐ Double-occupancy room

Nature of the illness/injury resulting in hospitalisation: .....

.....

Surgical intervention (if any): .....

Date first symptoms appeared: .....

Does the beneficiary have multiple insurance policies that cover the same occurrence? ☐ No ☐ Yes

If Yes, name and address of the insurance provider and policy number:

.....

.....

.....

For disability coverage claims:

What is the start date for the occupational incapacity? ..... / ..... /.....

Did the staff member have disability coverage through his/her previous employer? ☐ No ☐ Yes

If Yes, please provide us with the attestation issued by the previous insurer specifying the enrolment period and the covers.

To be filled out in case of accident

Type of accident: ☐ Non-occupational ☐ Traffic ☐ Sport
☐ Occupational ☐ School ☐ Other: .....

Does the beneficiary have multiple insurance policies that cover the same occurrence? ☐ No ☐ Yes

If Yes, name and address of the insurance provider and policy number:

.....

.....

Date and time of the accident: on ..... / ..... /..... at ..... hour ☐ AM ☐ PM

Location of the accident: .....

.....

Details of the occurrence:

.....

.....

.....

Opposing party (if any):

- name and address: .....

.....

- insurance company (name, address and policy number):

.....

.....

Witnesses: name and address: .....

.....

Did the police draw up a report? ☐ No ☐ Yes

If Yes, Police Department of: ..... op ..... / ..... /.....

Police report case number + copy of interview records (enclosed): .....

Who is responsible for the accident? (name and address of the liable party): .....

.....

Did the accident arise while in the course of employment or on the way to/from work? ☐ No ☐ Yes

If Yes, name and address of the employer:

.....

.....

Name of Workers' Compensation insurance provider? .....

.....

As a data controller, AG processes your personal data for the purposes mentioned in the general terms and conditions (the pension plan rules for sectoral supplementary pension), and in particular with a view to managing the supplementary benefits taken out by your employer or sector on your behalf (supplementary pension and/or occupational health insurance) and entrusted to AG for management purposes. More information about the processing of your personal data can be found in the general terms and conditions (the pension plan rules for sectoral supplementary pension) and in our Privacy Notice on www.ag.be.

Processing of special categories of personal data

- I, undersigned, explicitly agree to the processing of my health data by AG and my authorized representatives for the purpose of describing the risk and/or handling the claim, including the establishment of statistics.
- I, undersigned, explicitly agree to the processing of my personal data relating to criminal convictions and offences by AG and my authorized representatives for the purpose of handling the claim.

AG is controller for the processing of these data and undertakes to comply with its obligations under the applicable privacy legislation.

I have been informed about my right to withdraw my consent at any time. I acknowledge that in this case AG will be unable to perform the contractual relationship.

I hereby declare that all answers provided in this form are true and complete.

Drawn up in ..... on ..... / ..... /.....

Signature of the participant:

0079-8141635E-28062022